STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004972	A. BUILDING: _____ B. WING _____	09/26/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANCISCAN ST FRANCIS HEALTH - INDIANAPOLIS	8111 S EMERSON AVE INDIANAPOLIS, IN 46237

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit is for the investigation of 3 State hospital complaints. Complaint: #IN00123591-Unsubstantiated; lack of sufficient evidence. #IN00122680-Unsubstantiated; lack of sufficient evidence. #IN00122135-Substantiated; no deficiencies related to allegations cited. Survey Date: 09/26/13 Facility #: 004972 Surveyor: Linda Dubak, R.N. Public Health Nurse Surveyor Fransican St Francis Health-Indianapolis is in compliance with 410 IAC 15-1.5-10, Utilization Review and Discharge Planning, 410 IAC 15-1.5-6, Nursing Services, 410 IAC 15-1.5-2, Infection Control, Indiana Hospital Licensure Rules. QA: claughlin 10/21/13	S 000		